DRUG PLAN / INFORMATION SHEET

Company: _____ Operator Contractor Other_____(circle one)

Administrator of Drug Plan: _____
(Name) (Title)

Alternate Administrator: _____
(if needed) (Name) (Title)

COVERED EMPLOYEE'S DATA

Name	Title	If supervisor, date of training	Date coverage started	Date removed from coverage	Operator's employee	If no, name of contractor
					Yes or No	
					Yes or No	
					Yes or No	
					Yes or No	
					Yes or No	
					Yes or No	
					Yes or No	
					Yes or No	
					Yes or No	
					Yes or No	
					Yes or No	
					Yes or No	
					Yes or No	
					Yes or No	
					Yes or No	
					Yes or No	
					Yes or No	
					Yes or No	
					Yes or No	